MDR Tracking Number: M5-04-4111-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 08-02-04.

The IRO reviewed chiropractic manipulative therapy spinal, therapeutic exercises, ultrasound therapy, paraffin bath therapy, durable medical equipment, electrical stimulation rendered from 09-02-03 through 10-14-03 that denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. The IRO determined that the paraffin bath therapies and the durable medical equipment **were** medically necessary. The IRO determined all remaining services and procedures performed **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for paraffin bath therapies, durable medical equipment, chiropractic manipulative therapy spinal, therapeutic exercises, ultrasound therapy and electrical stimulation. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-25-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99080-73 for dates of service 09-12-03 and 10-06-03 denied with denial code V. This service is a TWCC required report and will be reviewed as a fee issue. The requestor did not submit relevant information to support delivery of service for date of service 09-12-03; therefore no reimbursement is recommended. Relevant information to support delivery of service for date of service 10-06-03 was submitted; therefore reimbursement in the amount of $15.00 per the Medical Fee Guideline effective 08-01-03 is recommended.

CPT code 98940 for date of service 08-06-03 denied with a G/U687 denial code - procedure mutually exclusive to another procedure on the same date of service. Per Rule 133.304(c) the respondent did not specify which code the service is mutually exclusive to. Reimbursement for CPT code 98940 for date of service 08-06-03 is recommended in the amount of $30.14 per the Medical Fee Guideline effective 08-01-03.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 08-06-03 through 09-30-03 in this dispute.

This Findings and Decision and Order are hereby issued this 27th day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:
MDR Tracking Number: M5-04-4111-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas

Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Items Reviewed:

1. Notification of IRO assignment, Table of Disputed Services, carrier EOBs
2. Treating doctor's narrative office notes/examinations for dates of service ___, 05/14/03, and 08/05/03
3. "Daily Treatment Logs" from treating doctor for dates of service 02/26/03 through 10/14/03
4. Functional Capacity Evaluation and narrative report from treating doctor dated 09/19/03
5. Narrative from orthopedic examination dated 06/24/03
6. NCV/EMG report and results dated 08/27/03
7. Various TWCC-73 reports

Patient is a 44-year-old female service representative for Southwestern Bell who, on ___, sustained a repetitive motion trauma to her bilateral hands and wrists. She presented to a doctor of chiropractic that same day and initiated conservative chiropractic care, physical therapy and rehabilitation.

REQUESTED SERVICE(S)
Chiropractic manipulative therapy, spinal (98940), therapeutic exercises (97110), ultrasound therapy (97035), paraffin bath therapy (97018), durable medical equipment dispensed (Biofreeze™gel – E1399), and electrical stimulation, unattended (G0283) for dates of service 09/02/03 through 10/14/03.

DECISION
The paraffin bath therapies (97018) performed and the durable medical equipment that was dispensed are approved. All remaining services and procedures that were performed are denied.

RATIONALE/BASIS FOR DECISION
The documentation and diagnosis in this case adequately established the medical necessity for paraffin bath treatments due to its effectiveness in increasing circulation and stretching contractures. Therefore, these services were supported.

However, neither the documentation nor the specific diagnosis submitted supported the medical necessity of performing spinal manipulation, particularly because the injury was limited to the wrists and hands. Therefore, the chiropractic manipulative therapies (98940) were denied.

In addition, the records submitted and the EOBs from the carrier demonstrated that this patient received a significant amount of supervised care prior to the dates in dispute, and could have been transitioned into a home program by 09/02/03. There is no evidence in the documentation submitted to support the need for continued monitored therapy after 09/02/03. Services that do not require "hands-on care" or supervision of a health care provider are not considered medically necessary services even if the services were performed by a health care provider. Performance of activities that can be performed as a home exercise program and/or modalities that provide the same effects as those that can be self applied are not indicated. Any gains that were obtained during this time period would likely have been achieved through performance of a home program.

Therapeutic exercises may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. In other words, the provider failed to establish

why the services were required to be performed one-on-one in this case.

Insofar as the ultrasound therapy was concerned, the therapeutic effects are similar to paraffin bath therapies. As such, performance of both on the same patient encounter was duplicative and not medically necessary.